Primary Care Physician Advisory Committee
Meeting Minutes, March 20, 2013

Members Present: David Ashley MD, Stanley Block MD, Mark Braun MD, Michael Felder DO MA, Michael Fine MD (Director), Steven Kempner MD, Kathryn Koncsol-Banner MD (Co-Chair), Elizabeth Lange MD (Co-Chair), Diane Siedlecki MD, Patrick Sweeney MD PhD MPH, Peter Simon MD MPH, Guests: Rosa Baier, Stefan Gravenstein MD, Deidre Gifford MD, David Keller MD, Yvette Mendez

Members and Alternates Unable to Attend: Gregory Allen, Jr., DO; Munawar Azam, MD; Thomas Bledsoe, MD; Jeffrey Borkan, MD, PhD; David Bourassa MD, Nitin Damle, MD; Steven DeToy; Sarah Fessler, MD; Patricia Flanagan MD; Cynthia Holzer, MD, CMD;Steven Kempner MD, Christopher Koller, Anne Neuville RNP, Albert Puerini MD, Richard Wagner MD, Newell Warde PhD, Ana Novais MA,

Open Meeting/Old Business: PCPAC Co-Chair, Dr. Elizabeth Lange called the meeting to order at 7:30 AM.

The minutes of February 20, 2013 were approved.

1st Presentation: Medicaid Parity Under Health Care Reform – Dr. Deidre Gifford

This topic has been making the rounds from Medicaid to several primary care venues so people know about the PCP bump (Medicaid primary care fee increase). Getting closer to launching, and is looking for feedback from PCPAC members.

- The affordable care act requires Medicaid agencies to pay primary care providers at the Medicare rates from Jan. 2013 through Dec. 2014 to enhance access in anticipation of Medicaid's expansion for participating states in 2014.

Question - **Who is eligible?**

If you practice in family medicine, internal medicine, or pediatrics, includes various subspecialties. Also eligible are nurse practitioners and PA's for whom an eligible provider takes direct professional responsibility.
OBGYN is not eligible.

- Services eligible for fee increase are the E and M codes (99201, 99499) and also the vaccine administration codes (90471, 90472, 90473, and 90474).

Question -**Will I receive these increases automatically, or do I need to take some action?**

There are two ways you can be deemed eligible for this program. One is to be board certified in one of the specialties by either the American Board of Medical Specialties (ABMS) or by the American Osteopathic Association (AOA), or the American Board of Physician Specialties (ABPS). If you are not board certified you are still eligible but you have to attest to the Medicaid agency that 60% of the total Medicaid claims billed in the year prior were for the E and M and vaccine codes eligible for the increase.

Question - **How do I attest?**

If you are practicing and are board certified in one of the eligible specialties, but did not certify on your credentialing application that you are board certified, or you are not enrolled with one of the Medicaid Managed Care Organizations – (MCO's are either Neighborhood or United RIte Care), you can log on directly to the Rhode Island Attestation Portal and attest to your eligibility. If you are not board certified you must go on to the attestation portal and prove that 60% of your Medicaid billing was for the eligible E and M and vaccine code.

Other Questions:

- if provider is board certified and currently a provider for United RIte Care and Neighborhood health plans, will provider automatically be approved? Dr. Gifford recommended that everyone go on the attestation portal and confirm their name on the list. If your name is on the list, you will automatically get the approved for the increase. It is recommended to reassure that you are confirmed. NP's and PA's cannot attest independently, only physicians can attest. Their supervising clinician must go on the portal and list their name under them.

- In MA an NP needs to have a supervising physician on site in place where that NP is seeing a patient, and that is not the case in RI. So when you say a "supervising physician" is this a new rule, does a physician have to be on site for a NP to see a Medicaid patient to get the bump? Physicians need to take direct professional responsibility.

- Clarify whether or not a supervising physician needs to be on site. That it is each physician's individual decision as to whether or not a NP whom they co-sign for can be left alone to attend patients. A Physician must take full responsibility even if they are not on site.

- Another member asked if the deadline for all attestations is really for April 6, 2013. The attestation portal is being built by HP and it will become available the first week of April. You will have 60 days past the day it becomes available to attest. Whether you attest or your name is already on the list, you will receive payments retroactive to January 2013. If you pass the 60 days you will still be eligible to receive the fee increase but not from January 2013, but from the date of the attestation and forward. You can attest as long as the program is ongoing.

- Another member asked what the fee schedule would be. The fee schedule will be posted under the Medicare 2013-2014 fee schedule. She also clarified that you will only be getting what you billed. The last thing that was clarified was that by law, the money for the increase will go directly to the doctors, not any umbrella organization. If an individual is a salary employee, the individual will receive an increase in salary during the two years.

2nd Presentation: Patient Responsibilities – Michael Felder, DO; Stefan Gravenstein, MD, MPH; and Rosa Baier, MPH

Dr. Felder

The American Medical Association (AMA) has produced a document reviewing patient responsibilities.

- Does this differ, and do we agree with those overall? In addition, does this differ in the context of care transition.
- Example: a patient readies themselves to move from one setting from another, lets say from the hospital back to home, does the patient have a different kind of accountability for knowing what's going to happen to them so that they can follow through with the recommendations?

The reciprocal view of that would be: Do we as providers have a different kind of responsibility to make sure that they have learned what they need to know at discharge. An example of that would be if the patient cannot absorb the information that we are helping them with in the last 6 minutes of discharge, should they have somebody else available that helps absorb it with them, and is that a responsibility of the patient to provide such a person, and do we have to identify that.

The larger context of this being, what are those patient responsibilities, do they differ, and how do we think about them, and is this something we want to codify?

- Features of what we want: we want to think about something we can measure.
- In the context of our discussion we want to think in aspirational terms because whatever we think ought to happen may not be feasible today. (But knowing that is what we would like to have happen helps us figure out how to build the infrastructure for it happening.

Rosa Baier

This discussion is arising from our previous presentation to this group about the care transitions best practices that we have defined for different health care settings. There was some discussion earlier at the time we talked about best practices about “these are the things that we can do, but what are the responsibility of the patient”?

- Goal: for PCPAC members to help come up with the list of things that should be codified in patient best practices.
- Looking at every person/provider that participates in transitional care and trying to figure out what are those aspirational best practices that we as a community can define and aspire to achieve.

- Dr. Fine shared his concerns on certain patient responsibilities especially with requiring patients to bring an alternative person seeing that the majority of elderly patients do not have any alternative friend or family members to be present during an encounter. It should be taken more into consideration that not everyone lives in a “nuclear” family any more.

- Mr. Gravenstein commented that the aspirational question vs. what is realistic may be a little divergent, and that may be part of what needs to be discussed. So in the example of that patient, if they know they are going to have that issue, should they prep for that differently? Should they have someone number to call that can also be handed the information instead of just them? How does that look, and what is it that we think should happen? This is the same thing when a patient comes from a nursing home. Is the note that we scribble sufficient information? That patient is clearly not going to remember everything they are told.

- Dr. Fine agrees that they are all very good questions, but what concerns him is that he sees this making patients more hesitant to get care because they don’t have enough resources (including family) to do it.

- Dr. Felder commented that the biggest challenge is making sure the patient understands what they are being told during discharge, there are no questions, quizzes, nothing to assure the patient comprehends.

- Dr. Fine added that maybe home visits may be helpful to assure that patients are actually understanding their transitional instructions.

- Ms. Baier also commented that as provider best practices it has been attempted to interact or do some teach-back with the patient after they have received their instructions to assure that they understand what they have been told.

- What is the patient accountable for after everything has been assessed, including patient accessibility at home and home situation, lack of help, etc.?

- Ms. Baier also expressed that there is a difference between patient rights and responsibilities.

- Dr. Banner: One way to assess all of this could be yes they have all of the resources, or no they do not have all of the resources. If yes, then what is their responsibility? Can they provide a person on the day of discharge, and then what are their responsibilities on following through? We automatically assume that understanding means following through, and that is not the case.

- Ms. Baier commented that on the Patient responsibilities guidelines patients are obligated to either follow their treatment plan or verbally tell their doctor if any changes need to be made.

- Dr. Felder: One of the most difficult implications is that we assume that patients will come through with the same healthcare goals that we all have. Since we know that all patients do not articulate or express these healthcare goals in their actions. If they are not healthy, we know we are now in a system of pay for performance measure. So when the physician says, I cannot get this patient healthy and realizes their patient has yet to express any desire to be healthy then the physician finds him/herself reassessing their patients' responsibility to which the physician is held accountable for when he is paid for his measures. So when a physician is paid less due to a non compliant patient, we have to ask ourselves to what point will we hold the physician responsible for getting the patient to comply in order to become healthy?

- Another commented: So in this physician/patient responsibility discussion it is important to understand that if one does not work the other one will fail as well. These measures are also reflective on each other in terms of the success, and this is what makes it more difficult of a discussion rather than just saying lets review the patients responsibilities according to the AMA.

- Dr. Fine's overall concern with the notion of patient responsibility led him to conclude that "we license physicians, we don't license patients". However, he did agree with Dr. Felder's comments on holding physicians responsible for patients' outcomes and behaviors. This seems to be the beginning of some rethinking of that accountability and finding some way to measure the extent to which patients accept responsibly. Hold physicians accountable only when there is that acceptance. Which is a fairly interesting and tricky process. We hold ourselves and we are holding the health care system accountable for outcomes, and I

am not sure that is what patients are asking from physicians. Much of what patients ask from physicians are relationships, not outcomes. We have layered the public health interest on top of that. It is important to separate the relationship piece, which is important to patients, from the public health piece, which is important to society, as we think about how to address and pay physicians, whom have been traditionally paid according to the relationship piece, never really recognizing the public purpose of primary care.

- Ms. Baier: This conversation started with the physicians best practices. When the topic was first brought up, every one agreed that there were some very logical ideas, but nothing would be successful unless the patient became responsible for some things on their part.

- Another member commented about a patient activation measure that is getting a lot of attention, and has correlated with improved outcomes. Maybe what people mean is moving people along the scale of activation rather than looking at the engagement of the patient in their self care, which is a little bit beyond the physician-to-patient relationship.

- Another member suggested that activation/self-care motivation has to be part of the diagnostic coding when there is an assessment taking place. Then, there can be a risk adjustment, and the patient population will also be looked at. Then it will not be fair if every body begins to walk away from unmotivated or depressed individuals because they will no longer have the power to impact the outcome of their health.

- Another member stated that eventually physicians will be paid based on outcome and will then seek patients who do have the resources and motivation to have good outcomes, but will no longer seek patients like the inner city poor, depressed, or non-compliant, or any other folks who will have a tougher time getting a better outcome.

- Another member suggested see in real time if they are actually filling their prescriptions. The member said that he receives plenty of letters on a daily basis letting me know whether or not a patient is doing what they need in order to have a successful outcome. He had a patient insisting he was taking his meds, while receiving information of no refills for years. However, he actually was taking his meds.

- Note that not all plans are included in the prescription tracking program.

- Another member said that it would be nice if we actually knew if patients were following the regimen perscribed. We all know patients will always tell you they are taking their medication whether they are or are not.

- Dr. Felder: So would one of the measurables be to ask patients to bring in a brown bag (with all meds), as their concrete way of demonstrating they are taking an active role in their health.

- Another member described an experiment in Chicago (heard on NPR) a program on paying teachers: there were three options: did not pay the teacher based on the outcomes, paid the teachers a bonus based on the outcomes, and they paid the teachers ahead and there was a payback at the end if the outcomes were not reached -- the last one was the only one that made it.

- Another member stated that physicians are the ones that set these targets. We have to be very careful, certainly in my little area of asthma, there are all sorts of things that have changed over time. Now people are talking about inhaled steroids on demand as opposed to an ongoing basis. I think we need a little humility, and I am afraid physicians have not been very good at that.

- Dr Felder: Some things like the virtues of telling the truth are not within our domains to measure. On the other hand filling a prescription is something we can measure. I think we need a sense of the extent we can hold physicians responsible. Patients need to understand that when they are not healthy they not only impact themselves and the physicians, but also others.

- Another member stated some employers are beginning to penalize and fire employees who do not take care of themselves health wise, and these patients after years of lacking motivation, come back extremely motivated to get better.

- Dr. Fine: I have always thought that primary care has always been the most intellectually challenging enterprise in the US. Hearing from the perspective of the board of medical licensure and discipline, I am very worried about a discussion that says patients are responsible and physicians are not.

- Dr. Felder: I don't think anybody is suggesting that.

- Dr. Fine: It seems to me that many patients do not understand the consequences of choices; and for employers, incentives are about limiting their costs. Understanding each of the different functions of each of the actors in this dynamic system (of

healthcare) is what we are about. I am cautious about giving up and setting goals. From a public health perspective what were about is improving outcomes. How we set those goals and the kinds of incentives, carrots and sticks to get to those goals is complicated. From my perspective, the notion of individual autonomy and personal freedom needs to be respected in the context of those goals. Everybody in the dynamic system has a different role, and how those roles play together, collide and crash sometimes, that is when this becomes interesting.

- Another member was concerned about employers asking employees to get verification from their PCP that they are reducing their risk factors, and if not, may be fired.

- Dr. Fine: We want to create an environment in which change that can lead to better outcomes and lower cost is possible. Employers obviously want to be focused on the lower cost, and sometimes better outcomes to achieve lower cost. The political and legal world is making sure patients have freedom and autonomy. Hopefully we get better outcomes. Is it right for employers to do what you are describing? I think that is an interesting ethical debate and I am not sure where I am on it. What makes this so very interesting is we are trying to figure out what incentives are sufficient and necessary to create positive health outcomes..

- Dr. Gravenstein: Something that has yet to be put out on the table is if a patient is discharged from the hospital, do they have an accountability for identifying who their PCP is? Also the reciprocity of this is: are there PCPs out there who are willing to be assigned a patient who does not have an assignment? One of the benefits of the ACO is that the patient will be paid $150 for identifying the PCP and another $150 for doing an annual health visit. The amazing thing to me is that still a high proportion of the folks on this plan do not have a PCP.

- Dr. Fine: By paying the patient $300 a year for those two things they have actually paid the patient more than the average primary care physician for a years worth of care.

- Ms. Baier: For the next discussion we do need to have the physician and patient responsibilities side by side. We also have not talked about who is holding the patient accountable. We have been talking about potentially excluding risk stratifying in some way out of that population. It may be really helpful to know what percent of patients (only 20% or 75% of my patients) can do whatever we are defining. We are not talking about holding the physicians accountable for that, we are talking about in some ideal world figuring out how to hold the patient accountable for that.

- Another member shared a personal experience of having her thyroid removed. She expressed how unpleasant the experience was seeing as to how she is nearly the perfect patient. I think we are so far from having a system in which we can ethically hold patients responsible because the healthcare system is so broken.

- Dr. Fine stated that he learned a lot from this discussion, and what I learned very specifically is, as we think about quality improvement, one of the things that eventually needs to get into the equation is some measure of patient activation - some way to control for not just age and morbidity but patient engagement. Because it is one thing if you have and are able to participate with an engaged patient population. Another thing if you take care of huge numbers of people who are poor, African American, or from another culture, who have high levels of social stresses that people in our world really experience. We have to find some way to compensate for what we are going to ask of providers to do in terms of evidence for improving population health.

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The meeting was adjourned at 8:45 AM.

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